



State of California

OFFICE OF THE INSPECTOR GENERAL

MATTHEW L. CATE, INSPECTOR GENERAL

FOR IMMEDIATE RELEASE

December 29, 2005

For Additional Information Contact:

Brett H. Morgan

Chief Deputy Inspector General

(916) 830-3600

**Youth who committed suicide at state facility
had been locked in isolation for eight weeks**

The Office of the Inspector General reported today that an 18-year-old youth who committed suicide last summer at the N. A. Chaderjian Youth Correctional Facility had been locked in his room alone nearly 24 hours a day for eight weeks, during which time he received no mental health, education, exercise, family visits, or other services.

The youth was a member of a northern Hispanic gang that had violently attacked employees at the facility, prompting an extended lockdown in which the youths associated with the gang were allowed out of their rooms only about three times a week for showers or for occasional disciplinary hearings or sick call. The youth who eventually committed suicide was included in the lockdown, even though he had not been involved in the attacks and had no history of assaulting the staff, because he refused to renounce his gang-related behavior.

According to facility employees, the purpose of the lockdown was to restore order and protect both staff and "wards," as youths incarcerated in state correctional facilities are called. As the lockdown continued, the administration tried to persuade the youths to end gang activities in order to earn back privileges. The staff recognized, however, that wards who did so were subject to violent retaliation by other gang members. The Inspector General noted that the situation left the ward in this case with two choices: renounce the gang and suffer potential reprisals or stay with the gang and continue to live in what he apparently saw as increasingly intolerable conditions.

The special review also found that during the entire eight-week period of the lockdown, the staff failed to conduct formal assessments of the youth's mental health needs even though there were signals that such assessments would have been appropriate. In addition, on the day of the suicide, the facility staff was slow to respond to signs that something was amiss, taking nearly 40 minutes to open the youth's door after they discovered he had covered up his windows and was not answering repeated inquiries about whether he was all right. When they finally did open the door, they found him unconscious, hanging from an upper bunk with a bed-sheet around his neck. He was pronounced dead at a nearby hospital an hour later.

In releasing the results of a 30-page special review into the circumstances surrounding the youth's death, Inspector General Matthew L. Cate said that even though the facility lockdown was justified at the beginning, the long period of isolation combined with the absence of core services may have contributed to the youth's suicide.

"This is yet another demonstration of the complete unacceptability of locking youths up for extended periods without access to the education and treatment so critical to rehabilitation efforts," said Cate.

"The extent to which the institution confined these youths to their rooms and deprived them of services is thoroughly inconsistent with the core mission of the Division of Juvenile Justice, which is to educate, treat, and train the young people entrusted to its care."

The Division of Juvenile Justice is the successor to the California Youth Authority, which was renamed in the reorganization of the state's correctional system that took effect July 1.

The Office of the Inspector General had criticized the California Youth Authority in the past for locking youths in their rooms nearly around the clock, first calling attention to the practice in December 2000 when it found from a sample of records that one in six wards at six state youth correctional facilities were locked up 23 hours a day. In a more recent statewide assessment, released in January 2005, the Inspector General found that only one institution had ended the practice and that 9 percent of a sample of wards in five facilities—243 youths—were still confined to their rooms almost continually, with minimal access to education, counseling, and treatment services. As a result of that finding, the Inspector General strongly urged the California Youth Authority to end the practice of locking wards in their rooms for long periods.

The N. A. Chaderjian Youth Correctional Facility has also come under strong criticism from the Inspector General in the past. Describing the facility as “a troubled institution,” the Office of the Inspector General released a comprehensive audit in May 2005 that found N. A. Chaderjian was failing to provide a safe environment for either staff or wards and was not providing youths with required education and treatment services.

The institution is one of eight youth correctional facilities operated by the Division of Juvenile Justice. Youths sent to N. A. Chaderjian are generally older and more serious offenders than those in the state’s other youth institutions.

In recent months, partly as a result of a class action lawsuit, the Division of Juvenile Justice has been attempting to implement an “open programming” model under which wards are to be allowed out of their rooms every day for meals, recreation, academic classes, vocational training, and treatment.

In the special review released today, the Office of the Inspector General repeated its earlier recommendation that state correctional officials immediately end the practice of isolating youths in their rooms for long periods of time and suggested that lockdowns extending more than 14 days should require written approval by the Secretary of the Department of Corrections and Rehabilitation. The Inspector General also recommended that facilities provide wards with at least minimum levels of mental health intervention during lockdowns.

The full text of the Inspector General’s public report of the special review into the circumstances surrounding the ward’s suicide can be viewed and downloaded from the Office of the Inspector General’s web site at <http://www.oig.ca.gov/>. To view the report, click on the report title, “Special Review Into the Death of a Ward at the N. A. Chaderjian Youth Correctional Facility.” on the home page or on the link entitled “Reports – Audit and Special Review Reports” under “N. A. Chaderjian Youth Correctional Facility.”

The Office of the Inspector General is an independent state agency responsible for oversight of the Department of Corrections and Rehabilitation. The office carries out its mission by auditing and investigating the department to uncover criminal conduct, administrative wrongdoing, poor management practices, waste, fraud, and other abuses by staff, supervisors, and management. The special review was conducted under the authority provided to the Inspector General in California Penal Code section 6126.